No. 300
10-48

FILED APR 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11526

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 765

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koch (rural)
c. LENGTH OF STAY (in this place) 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Robert Koch Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
d. STREET ADDRESS (If rural, give location) 2 North Eudlid

3. NAME OF DECEASED (Type or Print)
a. (First) Lester
b. (Middle)
c. (Last) Powell

4. DATE OF DEATH (Month) (Day) (Year) 3-15-50

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 11-2-91
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Clarkesville, Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Henry Powell
13b. MOTHER'S MAIDEN NAME Jenny Horne
14. NAME OF HUSBAND OR WIFE Marie Brown (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I
16. SOCIAL SECURITY NO. 492-20-8624
17. INFORMANT'S SIGNATURE OR NAME Hospital Records, Robt. Koch Hosp. ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH 1 yr (?)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 002X
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-24-50, *19*___, *to* 3-15-50, *19*___, *that I last saw the deceased alive on* 3-15-50, *19*___, *and that death occurred at* 11:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Thomas H. Bolst MD
23b. ADDRESS Robert Koch Hospital
23c. DATE SIGNED 3-16-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3-24-50
24c. NAME OF CEMETERY OR CREMATORY Nat. Jefferson Barracks
24d. LOCATION (City, town, or county) St Louis (State) Mo.

DATE REC'D BY LOCAL REG. MAR 23 1950
REGISTRAR'S SIGNATURE Herbert R Domke Jr
25. FUNERAL DIRECTOR'S SIGNATURE G. W. Bruce ADDRESS 4469 Washington

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 12 1950

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. ....., working under my personal supervision.

Student .....
Student Embalmer

Signed Frederick P. Stark

Licensed Embalmer No. 4599

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.